STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	10/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

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W000000		W000000		
	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: September 24, 25, October 15 and 21, 2014. Facility number: 001010 Provider number: 15G496 AIM number: 100245040 Surveyor: Amber Bloss, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/5/14 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement and/or develop a abuse/neglect policy to thoroughly investigate and prevent falls with major injuries for a client with a history of falls for 1 additional client (#7). Based on record review and interview, the facility failed to implement and/or develop an abuse/neglect policy to report, thoroughly investigate and prevent client to client abuse for 2 of 2 internal accident/incident reports for client to client abuse for 1 of 4 sampled clients (#1) and 1 additional client (#7). Based on record review and interview, the facility failed to implement and/or develop an abuse/neglect policy to thoroughly investigate an injury of unknown origin for 1 of 1 BDDS (Bureau of Developmental Disabilities Services) report for injury of unknown origin for 1 of 4 sampled clients (#4). Findings include: 1) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to	W000149	**Toensure that established agency policies and procedures for investigations andincident reporting are being implemented and executed as written, the followingcorrective action(s) will be implemented:** 1) Allstaff located at 2333 Westdale Court (Westdale group home) will be re-trainedon the agency Personnel Policies and Procedures, Policy III:13: IncidentReporting. Completed Record of Trainings will be obtained and submitted uponcompletion of training. *Refer to Appendix A for Record of Trainingform to be used.* 2) Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. *Refer toAppendix B for process outline.* To ensure that all investigations areconducted in a uniform and consistent manner, all Residential House Managers,Qualified Development Disability	11/20/2014

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	9/25/14 were reviewed. A BDDS report dated 7/5/14 indicated "[Client #7] was visiting the [museum] with other housemates and staff was walking through an exhibit. Staff was assisting another client going up a ramp when [Client #7] missed a step and fell forward, hitting her face on part of the exhibit (which looked like fake rock). The EMT (emergency medical technician)'s were called and she was transported with staff to [hospital] via ambulance. House manager and residential nurse were notified immediately." The report indicated "[Client #7] had a CT (computerized topography) scan, and required 6 stitches which went from the bottom of her lip up to her nose. She has two fractures, one in the nasal cavity and one in the sinus cavity. Both are expected to heal on their own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the nurse. If needed, follow up with her primary care physician will be done to		Professionals, Nurses, the Director, and theResidential Services Coordinator will be trained on the newly establishedinvestigation process outline. *Refer toAppendix C for Record of Training form to be used in documenting training*. 3) Toensure that all incidents of significant injury, injury of unknown origin, andpeer-to-peer aggression are properly documented and investigated. Any incidentswill be reported to the Residential Services Coordinator. The ResidentialServices Coordinator will complete the appropriate documentation and maintainfor record keeping purposes. *Refer toAppendix D to review forms that will be implemented occurrences of eitherincident*. 4) Lastlyto ensure that incidents have been reported and investigated in the manner asoutlined in agency policies, all investigations packets, regardless of type,will have an investigation process checklist included. The checklist will becompleted by the	

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	check the progress of any injuries/healing, or any complaints that [Client #7] has." A BDDS report dated 8/8/14 indicated "[Client #7] was out in the community with her housemates and staff, having a picnic and taking a walk around the downtown area. During the walk, [Client #7] tripped over a curb and fell, scraping her elbow. Staff administered first aid and continued walking for a bit. About 20 minutes later, she began to collapse, at which time she was assisted to the ground." The report indicated "the ambulance was called as a precaution, and she was taken to [hospital] ER (emergency room) as a precaution. The nurse and QDDP (Qualified Developmental Disabilities Professional) were notified immediately." The report indicated all labs and x-rays were within normal limits at the hospital except Client #7 "had a x-ray of her right elbow which showed that there was some fluid present that the Dr. (doctor) felt may be consistent with a hairline fracture of her elbow." The report indicated "A follow up with orthopedic [doctor] is recommended for 4 days from now. [Client #7] is to wear a sling at all times except when showering until she follows up with [orthopedic doctor]. It is also recommended that [Client #7] follow up		Residential Services Coordinator as he/she is conducting theinvestigation. Upon the conclusion of the investigation, all investigationmaterials including the checklist will be given to the Vice President ofResidential Services for review. The Vice President of Residential Serviceswill sign-off on the checklist and accompanying materials once all items havebeen reviewed and approved. *Refer toAppendix E to review investigation process checklist*.	

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	with [doctor] in 5 days. Due to the fact that [Client #7] has fallen 2 times in the last month the nurse is asking her physician for a PT evaluation. At this point in time, based on the tests that were ran, we do not see anything that points to a medical condition that would be contributing to her falling. She is scheduled to see [doctor] (ophthalmologist) on 8/11/14 @ (at) 10 am. This visit should be able to determine whether or not her vision is the cause of these falls. [Client #7]'s gait is normally steady." The report indicated "also, her ears were checked at the ER and there was no ear infection or fluid accumulation present." On 10/15/14 at 4:10 PM, record review indicated Client #7's diagnoses included, but were not limited to, intellectual disabilities, seizure disorder, and hydrocephalus (excessive water on the brain). Record review indicated Client #7 had a fall risk plan dated 11/26/13 and revised date 10/1/2014 which indicated Client #7's "diagnosis of Hydrocephalus and Cataracts cause her experience poor balance and little depth perception. She needs assistance walking on uneven, slick or graduated surfaces. She does not like walking in the winter time when snow and ice are on the ground. She will often refuse to walk on grass and find a path			

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	with staff assistance no matter how much further it is to walk to her destination." The fall risk plan indicated "[Client #7] has a rolling walker now to assist her in being stable while walking. She is to use this whenever she is outside of the home." No further documentation was available to indicate Client #7's 7/5/14 reported fall was thoroughly investigated. No further documentation was available to indicate corrective action was developed to prevent recurrence of falls with injury after Client #7's 7/5/14 reported fall. On 10/15/14 at 12:25 PM, the Administrator indicated Client #7's team wanted to rule out medical causes of falls after the 8/8/14 reported fall. The Administrator indicated Client #7 had her ears and eyes checked, has had physical therapy, and has seen her primary care physician. The Administrator indicated there was no investigations of Client #7's falls with major injury. 2) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. An internal accident/incident report dated 7/23/14 indicated "[Client #1] was sitting on couch watching tv (television) and other			

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	consumer was vacuuming and tired (sic) to move [Client #1] and she wouldn't so other consumer hit her on her left upper arm. There is redness and may cause bruising." No further documentation was available for review to indicate which "other consumer" hit Client #7. An internal accident/incident report dated 7/2/14 indicated "[Client #7] was pushed into the wall on her left side. There is no bruising shown at this time." The report did not indicate who pushed Client #7. Both reports indicated "REPORT MUST BE TURNED IN WITHIN ONE BUSINESS DAY OF ACCIDENT/INCIDENT TO SUPERVISOR AND AGENCY NURSE." The report indicated the initials of the following as have reviewed the report: Supervisor, Agency Nurse, QDDP (Qualified Developmental Disabilities Professional), Vice President, Human Resources, Safety Manager, Safety Coordinator, and President. No further documentation was available for review which indicated the incidents of client to client abuse were reported to the state agency BDDS. During an interview on 10/15/14 at 2:35 PM, the facility Administrator indicated it is the facility policy that all incidents of			

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	client to client abuse are to be reported and investigated. The Administrator indicated no further documentation was available to indicate the incidents involving clients #2 and #7 were investigated. The Administrator indicated client to client abuse should be investigated on the facility formal's investigation format. 3) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 and investigations were reviewed. A BDDS report dated 7/12/14 indicated "staff was assisting [Client #4] in the shower this afternoon and noted that there was a large bruise on the inside of her upper left thigh. The bruise looks fresh, a dark purple, and is about 3.5 inches across." The report indicated "staff asked [Client #4] how she got it but she couldn't tell them where it came from. There have been no reported falls at the home, and QDDP (Qualified Developmental Disability Professional) will check with the workshop on Monday to clarify. She does bump into walls sometimes when walking. Staff notified the QDDP and the Residential Nurse who was on call." The report indicated "QDDP will follow up with her workshop supervisor on Monday to			

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	determine if there was a fall or any bumps with the wall etc. Residential Nurse will notify her Primary care physician (sic) and follow any instructions given. Staff will monitor the size of the bruise and document if [Client #4] has any pain." The "Investigation of Injury of Unknown Origin" dated 7/12/14 indicated Client #4 had a "3.5 inch across dark purple bruise on inside of upper left thigh." The investigation indicated "Consumer (Client #4) has very little verbal skills and when asked how she got it she could not tell them where." The investigation indicated "spoke with Residential Q (Qualified Intellectual Disabilities Professional) and staff regarding the bruise. There was no fall reported nor did any of them know about the bruise until it was noticed that day." The investigation indicated "spoke with [Supervisor of Dayprogram] in regards to this and she had no knowledge of [Client #4] falling or bumping into anything that would cause bruising." The investigation did not indicate which residential DSPs (direct support professionals) were interviewed. The interviews of staff were not included in the investigation. On 10/15/14 at 2:35 PM, the facility Administrator indicated injuries of			

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	unknown origin should be thoroughly investigated. On 9/25/14 at 11:35 AM, a review of the facility policy on "Prohibition of Violations of Individual Rights" (undated) indicated "In order to protect the general welfare of persons served, [facility] strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of any individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency." The policy indicated on "Reporting" that "it is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation or violation of individual rights to report it immediately, verbally and/or in writing to the President or, if the President is unavailable, the Director, Human Resources." 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to report 2 of 2 incidents of client to client abuse to the state agency BDDS (Bureau of Developmental Disabilities Services) for 1 of 4 sampled clients (#1) and 1 additional client (#7) in accordance with state law. Findings include: On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. An internal	W000153	**Toensure that established agency policies and procedures for incident reportingis being implemented and executed as written, the following corrective action(s)will be implemented:** **1)** All staff located at 2333 WestdaleCourt (Westdale group home) will be re-trained on the agency Personnel Policiesand Procedures, Policy III:13: Incident Reporting. Completed Record ofTrainings will be obtained and submitted upon completion of training.	11/20/2014

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	accident/incident report dated 7/23/14 indicated "[Client #1] was sitting on couch watching tv (television) and other consumer was vacuuming and tired (sic) to move [Client #1] and she wouldn't so other consumer hit her on her left upper arm. There is redness and may cause bruising." There was no further documentation available for review which indicated the incident was reported to BDDS. An internal accident/incident report dated 7/2/14 indicated "[Client #7] was pushed into the wall on her left side. There is no bruising shown at this time." There was no further documentation available to indicate this incident was reported to BDDS. Both reports indicated "REPORT MUST BE TURNED IN WITHIN ONE BUSINESS DAY OF ACCIDENT/INCIDENT TO SUPERVISOR AND AGENCY NURSE". The report indicated the initials of the following as have reviewed the report: Supervisor, Agency Nurse, QDDP (Qualified Developmental Disabilities Professional), Vice President, Human Resources, Safety Manager, Safety Coordinator, and President. No further documentation was available for review which indicated the incidents of		*Refer to Appendix A for Record of Training form to be used.*	

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	client to client abuse were reported to the state agency BDDS. During an interview on 10/15/14 at 2:35 PM, the facility administrator indicated all incidents of client to client abuse are to be reported and investigated. The administrator indicated both incidents of client to client abuse involving clients #1 and #7 should have been reported to BDDS. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 BDDS (Bureau of Developmental Disabilities Services)	W000154	**Toensure that established agency policies and procedures for investigations arebeing implemented and executed as written, the following corrective action(s)**	11/20/2014

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	report of injury of unknown origin for 1 of 4 sampled clients (#4). Based on record review and interview, the facility failed to thoroughly investigate a fall with major injury for 1 additional client (#7). Based on record review and interview, the facility failed to thoroughly investigate client to client abuse for 2 of 2 incidents of client to client abuse reviewed for 1 of 4 sampled clients (#1) and 1 additional client (#7). Findings include: 1) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. A BDDS report dated 7/12/14 indicated "staff was assisting [Client #4] in the shower this afternoon and noted that there was a large bruise on the inside of her upper left thigh. The bruise looks fresh, a dark purple, and is about 3.5 inches across." The report indicated "staff asked [Client #4] how she got it but she couldn't tell them where it came from. There have been no reported falls at the home, and QDDP (Qualified Developmental Disabilities Professional) will check with		**willbe implemented:** 1) Toensure that all incidents of significant injury, injury of unknown origin, andpeer-to-peer aggression are properly documented and investigated. Any incidentswill be reported to the Residential Services Coordinator. The ResidentialServices Coordinator will complete the appropriate documentation and maintainfor record keeping purposes. *Refer toAppendix D to review forms that will be implemented occurrences of eitherincident*. 2) Toensure that incidents have been reported and investigated in the manner asoutlined in agency policies, all investigations packets, regardless of type,will have an investigation process checklist included. The checklist will becompleted by the Residential Services Coordinator as he/she is conducting theinvestigation. Upon the conclusion of the investigation, all investigationmaterials including the checklist will be given to the Vice President	

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	the workshop on Monday to clarify. She does bump into walls sometimes when walking. Staff notified the QDDP and the Residential Nurse who was on call." The report indicated "QDDP will follow up with her workshop supervisor on Monday to determine if there was a fall or any bumps with the wall etc. Residential Nurse will notify her Primary care physician (sic) and follow any instructions given. Staff will monitor the size of the bruise and document if [Client #4] has any pain." The "Investigation of Injury of Unknown Origin" dated 7/12/14 indicated Client #4 had a "3.5 inch across dark purple bruise on inside of upper left thigh." The investigation indicated "Consumer (Client #4) has very little verbal skills and when asked how she got it she could not tell them where." The investigation indicated "spoke with Residential Q (Qualified Intellectual Disabilities Professional) and staff regarding the bruise. There was no fall reported nor did any of them know about the bruise until it was noticed that day." The investigation indicated "spoke with [Supervisor of Dayprogram] in regards to this and she had no knowledge of [Client #4] falling or bumping into anything that would cause bruising." The investigation did not indicate which residential DSPs		ofResidential Services for review. The Vice President of Residential Serviceswill sign-off on the checklist and accompanying materials once all items havebeen reviewed and approved. *Refer toAppendix E to review investigation process checklist*.	

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	15G496	A. BUILDING 00 B. WING	10/21/2014

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	(direct support professionals) were interviewed. The interviews of staff were not included in the investigation. On 10/15/14 at 2:35 PM, the facility Administrator indicated injuries of unknown origin should be thoroughly investigated with staff interviews. 2) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. A BDDS report dated 7/5/14 indicated "[Client #7] was visiting the [museum] with other housemates and staff was walking through an exhibit. Staff was assisting another client going up a ramp when [Client #7] missed a step and fell forward, hitting her face on part of the exhibit (which looked like fake rock). The EMT (emergency medical technician)'s were called and she was transported with staff to [hospital] via ambulance. House manager and residential nurse were notified immediately." The report indicated "[Client #7] had a CT (computerized topography) scan, and required 6 stitches which went from the bottom of her lip up to her nose. She has two fractures, one in the nasal cavity and one in the sinus cavity. Both are expected to heal on their			

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	own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the nurse. If needed, follow up with her primary care physician will be done to check the progress of any injuries/healing, or any complaints that [Client #7] has." No further documentation was available for review which indicated the fall was investigated to indicate whether staff were following Client #4's fall plan at the time of the fall and/or whether Client #4's fall risk plan was adequate to prevent recurrent falls. A BDDS report dated 8/8/14 indicated "[Client #7] was out in the community with her housemates and staff, having a picnic and taking a walk around the downtown area. During the walk, [Client #7] tripped over a curb and fell, scraping her elbow. Staff administered first aid and continued walking for a bit. About 20 minutes later, she began to collapse, at which time she was assisted to the ground." The report indicated "the			

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	ambulance was called as a precaution, and she was taken to [hospital] ER (emergency room) as a precaution. The nurse and QDDP (Qualified Developmental Disabilities Professional) were notified immediately." The report indicated all labs and x-rays were within normal limits at the hospital except Client #7 "had a x-ray of her right elbow which showed that there was some fluid present that the Dr. (doctor) felt may be consistent with a hairline fracture of her elbow." The report indicated "A follow up with orthopedic [doctor] is recommended for 4 days from now. [Client #7] is to wear a sling at all times except when showering until she follows up with [orthopedic doctor]. It is also recommended that [Client #7] follow up with [doctor] in 5 days. Due to the fact that [Client #7] has fallen 2 times in the last month the nurse is asking her physician for a PT evaluation. At this point in time, based on the tests that were ran, we do not see anything that points to a medical condition that would be contributing to her falling. She is scheduled to see [doctor] (ophthalmologist) on 8/11/14 @ (at) 10 am. This visit should be able to determine whether or not her vision is the cause of these falls. [Client #7]'s gait is normally steady." The report indicated "also, her ears were checked at the ER			

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	and there was no ear infection or fluid accumulation present." No further documentation was available for review which indicated the fall was investigated to indicate whether staff were following Client #4's fall plan at the time of the fall and/or whether Client #4's fall risk plan was adequate to prevent recurrent falls. On 10/15/14 at 4:10 PM, record review indicated Client #7's diagnoses included, but were not limited to, intellectual disabilities, seizure disorder, and hydrocephalus (excessive water on the brain). Record review indicated Client #7 had a fall risk plan dated 11/26/13 and revised date 10/1/2014 which indicated Client #7's "diagnosis of Hydrocephalus and Cataracts cause her experience poor balance and little depth perception. She needs assistance walking on uneven, slick or graduated surfaces. She does not like walking in the winter time when snow and ice are on the ground. She will often refuse to walk on grass and find a path with staff assistance no matter how much further it is to walk to her destination." The fall risk plan indicated "[Client #7] has a rolling walker now to assist her in being stable while walking. She is to use this whenever she is outside of the home." On 10/15/14 at 12:25 PM, the			

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	Administrator indicated Client #7's team wanted to rule out medical causes of falls after the 8/8/14 reported fall. The Administrator indicated Client #7 had her ears and eyes checked, has had physical therapy, and has seen her primary care physician. The Administrator indicated there were no investigations of either of Client #7's falls with major injury in regards to the whether staff were following Client #7's fall risk plan and/or whether the fall risk plan was adequate to prevent recurrent falls. 3) On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. An internal accident/incident report dated 7/23/14 indicated "[Client #1] was sitting on couch watching tv (television) and other consumer was vacuuming and tired (sic) to move [Client #1] and she wouldn't so other consumer hit her on her left upper arm. There is redness and may cause bruising." There was no further documentation available for review to indicate the incident was thoroughly investigated to indicate whether staff			

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	followed all behavior support plans. An internal accident/incident report dated 7/2/14 indicated "[Client #7] was pushed into the wall on her left side. There is no bruising shown at this time." There was no further documentation available to indicate this incident was thoroughly investigated to indicate which client pushed Client #7 into the wall and whether staff were following all behavior support plans. During an interview on 10/15/14 at 2:35 PM, the facility Administrator indicated all incidents of client to client abuse are to be thoroughly investigated. The Administrator indicated both incidents of client to client abuse involving clients #1 and #7 should have been thoroughly investigated. The Administrator indicated the facility planned to investigate client to client abuse on the formal template they developed. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to develop appropriate corrective action to prevent recurrence of a fall with major injury for 1 additional client (#7). Findings include: On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. A BDDS report dated 7/5/14 indicated "[Client #7] was visiting the [museum] with other housemates and staff was walking through an exhibit. Staff was assisting another client going up a ramp when [Client #7] missed a step and fell forward, hitting her face on part of the exhibit (which looked like fake rock). The EMT (emergency medical technician)'s were called and she was transported with staff to [hospital] via	W000157	**Toensure approval that recurrence of falls with major injury are prevented whenpossible, the following corrective action(s) will be implemented:** 1) Inthe event of a fall with significant injury, the fall will be reported to theResidential Services Coordinator. The Residential Services Coordinator willthen ensure that all incidents of significant injury, injury of unknown origin,and peer-to-peer aggression are properly documented and investigated. TheResidential Services Coordinator will complete the appropriate documentationand maintain for record keeping purposes. *Referto Appendix D to review forms that will be implemented occurrences of eitherincident*.	11/20/2014

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	ambulance. House manager and residential nurse were notified immediately." The report indicated "[Client #7] had a CT (computerized topography) scan, and required 6 stitches which went from the bottom of her lip up to her nose. She has two fractures, one in the nasal cavity and one in the sinus cavity. Both are expected to heal on their own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the nurse. If needed, follow up with her primary care physician will be done to check the progress of any injuries/healing, or any complaints that [Client #7] has." A BDDS report dated 8/8/14 indicated "[Client #7] was out in the community with her housemates and staff, having a picnic and taking a walk around the downtown area. During the walk, [Client #7] tripped over a curb and fell, scraping her elbow. Staff administered first aid and continued walking for a bit. About		2) TheResidential Services Coordinator will report findings from investigations ofsignificant injury to the Residential House Manager and Residential Nurse.These staff members will in turn use this information to determine what, ifany, medical intervention is needed. 3) Ifthe fall is a result of a change in medical condition, the respective client'sFall Plan will be updated and revised to include measures to prevent futurefalls. All staff working in the home will be retrained on the revised FallPlan.	

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	20 minutes later, she began to collapse, at which time she was assisted to the ground." The report indicated "the ambulance was called as a precaution, and she was taken to [hospital] ER (emergency room) as a precaution. The nurse and QDDP (Qualified Developmental Disabilities Professional) were notified immediately." The report indicated all labs and x-rays were within normal limits at the hospital except Client #7 "had a x-ray of her right elbow which showed that there was some fluid present that the Dr. (doctor) felt may be consistent with a hairline fracture of her elbow." The report indicated "A follow up with orthopedic [doctor] is recommended for 4 days from now. [Client #7] is to wear a sling at all times except when showering until she follows up with [orthopedic doctor]. It is also recommended that [Client #7] follow up with [doctor] in 5 days. Due to the fact that [Client #7] has fallen 2 times in the last month the nurse is asking her physician for a PT evaluation. At this point in time, based on the tests that were ran, we do not see anything that points to a medical condition that would be contributing to her falling. She is scheduled to see [doctor] (ophthalmologist) on 8/11/14 @ (at) 10 am. This visit should be able to determine whether or not her vision is the			

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	cause of these falls. [Client #7]'s gait is normally steady." The report indicated "also, her ears were checked at the ER and there was no ear infection or fluid accumulation present." On 10/15/14 at 4:10 PM, record review indicated Client #7's diagnoses included, but were not limited to, intellectual disabilities, seizure disorder, and hydrocephalus (excessive water on the brain). Record review indicated Client #7 had a fall risk plan dated 11/26/13 and revised date 10/1/2014 which indicated Client #7's "diagnosis of Hydrocephalus and Cataracts cause her to experience poor balance and little depth perception. She needs assistance walking on uneven, slick or graduated surfaces. She does not like walking in the winter time when snow and ice are on the ground. She will often refuse to walk on grass and find a path with staff assistance no matter how much further it is to walk to her destination." The fall risk plan indicated "[Client #7] has a rolling walker now to assist her in being stable while walking. She is to use this whenever she is outside of the home." No further documentation was available to indicate corrective action was developed to prevent recurrence of falls with injury after Client #7's 7/5/14 reported fall.			

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	On 10/15/14 at 12:25 PM, the Administrator indicated Client #7's team wanted to rule out medical causes of falls after the 8/8/14 reported fall. The Administrator indicated Client #7 had her ears and eyes checked, had physical therapy, and has seen her primary care physician. The Administrator indicated there was no further documentation to indicate corrective action after Client #7's fall with major injury reported on 7/5/14 and 8/8/14 in regards to updating Client #7's fall risk plan on ambulating on community outings or additional training for staff. 9-3-2(a)			
W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to ensure medications were administered as prescribed by physician's orders for 1 of 4 sampled clients (#2) and 1 additional client (#8). Findings include:	W000368	**Toensure that all medications are administered as prescribed by physicians'orders, the following corrective action(s) will be implemented:** 1) Allstaff located at the location of 2333 Westdale	11/20/2014

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	On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. A BDDS report dated 9/17/14 indicated "During the 8pm narcotic count, staff noticed that [Client #2]'s 8 AM dose of Clonazepam (anti-anxiety) 1mg (milligram) was still in the bubble pack. Residential Nurse notified of the missed dose and the primary care physician's office was also notified. [Client #2] was to continue on with normal dosing, and was given his 8 PM dose." The report indicated "[Client #2] had slightly more anxiety throughout the day reported, but did not have any significant behaviors." A BDDS report dated 9/7/14 indicated "staff was packing [Client #2]'s medications so that he could go home for the afternoon/evening, and while packing his 8PM medications, staff noticed that he was out of his Cogentin (used to counter side effects of other medications) 2mg. He takes this medication twice a day, at 8am and 8pm. The staff notified [Client #2]'s primary care physician." The report indicated "[Client #2] will also miss his 8am dose on 910/2014. Residential Nurse will call the pharmacist in the morning to find out if this is a refill		Court (Westdale group home) willbe receive re-training on the agency medication administration policy CompletedRecord of Trainings will be obtained and submitted upon completion of training. *Referto Appendix F for Record of Training forms to be used.* It is the intent that this training will prevent future medicationerrors for the clients affected as well as all other clients residing in thehome.	

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	issue, etc." A BDDS report dated 8/18/14 indicated "[Client #8] missed his 8pm dose of Diazepam (anti-anxiety) 2mg tablet. It was noticed at 11pm when midnights did the narc (narcotic) count. The residential nurse was noticed and called PCP (primary care physician). The doctor said there would be no adverse side effects. He started the medication on 8/16/14." A BDDS report dated 8/14/14 indicated "[Client #2] missed his 8pm dose of Klonopin (anti-anxiety) 1 mg (2) at bedtime. It was noticed at 12am when [DSP (Direct Support Professional) #1] (staff) was doing his midnight med count. The residential nurse [RN] was notified and called his PCP (primary care physician). The doctor said there may be increased behavior and or (sic) anxiety, but should be no other adverse side effects and to continue with next dose as prescribed." On 10/15/14 at 12:25 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated clients #2 and #8 medications should have been administered according to physician's order. 9-3-6(a)			

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